We can show you more.®

Practical resources to aid in safeguarding residents and minimizing risk

Aging Services

HEALTHCARE

Contents

Introduction

Webster's New Collegiate Dictionary defines "process" as "a series of actions or operations conducing to an end." A risk management program is only as effective as its constituent processes, as they are the practical means by which abstract intentions and plans are translated into safe, quality resident care.

Over the years, CNA Healthcare has created various resources intended to help the leaders of healthcare organizations design and evaluate critical processes. These policy and form templates, best practice guides and self-assessment instruments first appeared in two client publications: *CareFully Speaking*®, a three-times-per-year, in-depth discussion of aging services liability issues, and *AlertBulletin*®, a shorter and more frequent newsletter addressing a wide range of current and emerging healthcare topics.

This special publication assembles a number of these resources into a convenient risk management toolkit. The 28 sections offer guidance on clinical, operational and strategic subjects of concern to aging services providers. The toolkit is designed to encourage a proactive and systematic approach to the task of enhancing resident safety and minimizing the overall level of organizational risk.

Topics range from formatting new policies and transforming organizational culture to reducing the likelihood of resident falls and enhancing pain management and nutrition practices. Within these areas, the resources focus on the fundamental elements of risk control, including policymaking, training, communication, supervision and documentation.

We hope you find these tools useful for such essential administrative tasks as creating forms and documents, educating staff and leadership, and assessing organizational protocols and strategy.

These risk management strategies and guidelines are not intended to provide legal advice or to serve as a professional standard. The sample forms, templates and tools are included for illustrative purposes only, and should be adapted to the needs of individual organizations and residents. As each organization presents unique services, risks and situations, and statutes may vary by state, legal counsel should be consulted prior to the application of these materials.

A risk management program is only as effective as its constituent processes, as they are the practical means by which abstract intentions and plans are translated into safe, quality resident care.

Sample Form: Policy and Procedure Template

Organizational policies and procedures benefit from a uniform format and consistent drafting process. The following policy template is designed to help aging services settings streamline the writing, review and approval phases of policy development.

I. HEADER

The header section should state the

- *title* of the policy (which should be brief and descriptive)
- *number* of the policy
- *section, department or unit* responsible for drafting the policy
- *organizational area(s)* to which the policy applies
- *current status* of the policy
- *dates* on which the policy was reviewed, approved and revised

II. PURPOSE

The purpose section should summarize the policy's objectives and note the reasons why it was needed.

III. DEFINITIONS

The definitions section should explain technical terms for the benefit of novice readers.

IV. POLICY

The policy section should

- *state the rationale for the policy,* including reference to external regulations, if applicable
- *establish the legal and ethical criteria* for assessing appropriateness of policy decisions
- *provide a framework* for the policy and procedure, including intended outcomes

V. PROCEDURE

The procedure section should

- *describe the process* clearly and accurately
- *identify the participants* and their responsibilities
- *offer step-by-step instructions* on how the policy is to be implemented
- *delineate materials and documents* needed to carry out the policy and procedure
- *refer to recognized guidelines or protocols* for accomplishing the task

VI. RELATED POLICY AND FORMS

The related policy section should

- *present companion policy statements* that help clarify the larger issues
- *refer to pertinent federal and state laws,* as well as accreditation and regulatory standards
- *direct the reader to other standardized and/or electronic forms* associated with the policy statement

VII. REVIEW

The review section should

- *list the necessary reviewers,* including, but not limited to, the department or unit manager, executive leader, the medical and nursing director, governing board, and chair of the policy and procedure review committee, if applicable
- *include a timeline* for the review and revision process
- *contain a signature block* to ensure documented approval

Sample Form: Report of Violent and/or Abusive Incident

All instances of violence involving residents, staff or visitors must be thoroughly and accurately documented for mandatory state reporting, legal defense and quality improvement purposes. The following report format is designed to help organizations maintain accurate and complete records of violent or abusive incidents occurring within the facility.

---

1. DISCOVERY AND LOCATION

Date reported or noted: _____ Date incident occurred: _____

Time incident occurred: _____ Day of week incident occurred: _____

Location of incident: _____

2. TYPE OF INCIDENT AND IDENTIFICATION OF INVOLVED PARTIES

Nature of act : ❑ Violent ❑ Abusive

Type of harm: ❑ Verbal ❑ Physical ❑ Psychological

Degree of harm: ❑ Severe ❑ Moderate ❑ Minor

Directed toward: ❑ Patient ❑ Staff ❑ Visitor/Other

Victim's name: _____

Suspected assailant was: ❑ Patient ❑ Staff ❑ Visitor/Other ❑ Unarmed ❑ Armed (specify weapon)_____

Suspected assailant's name: _____

3. DESCRIPTION OF INCIDENT

_____

Did any person leave the area because of the incident? ❑ No ❑ Yes, Destination: _____

4. FACTORS CONTRIBUTING TO THE VIOLENT/ABUSIVE INCIDENT

(As exhibited by suspected assailant)

❑ Prior history of violence ❑ Intoxication ❑ Grief reaction

Dissatisfaction with care (specify grievance): _____

Other (describe): _____

5. DISPOSITION OF EVENT

Incident resolved: ❑ No ❑ Yes

Call made to: ❑ Police ❑ Security

Reported to: ❑ Police ❑ State agency

Suspected assailant arrested: ❑ No ❑ Yes

Suspected assailant escorted off premises: ❑ No ❑ Yes

Suspected assailant left on own: ❑ No ❑ Yes

Suspected assailant restrained: ❑ No ❑ Yes, How: _____ By whom: _____

6. FOLLOW-UP ACTIONS

Report completed by: _____ Title: _____

Witness(es): _____

Supervisor notified (name): _____ Date and time: _____

Risk manager notified (name): _____ Date and time: _____

Patient's physician notified (name): _____ Date and time: _____

Family member/significant other notified (name): _____ Date and time: _____

Sample Form: Exit Interview Questionnaire

Exit interviews with departing employees represent an important tool in the effort to reduce staff turnover and enhance both morale and quality of care. The following sample questions can help encourage open discussion and reveal underlying workplace concerns.

GENERAL:

- What is your primary reason for leaving?
- Did any specific event trigger your decision to leave?
- What were the most rewarding and most frustrating aspects of your job?
- Before you resigned, were you offered any options for transfer within the organization?
- How could we have prevented your departure?
- Would you consider returning to work here? If not, why?
- Would you recommend employment at our facility to your friends? Why or why not?

JOB TRAINING AND ORIENTATION:

- Were job duties and expectations clearly explained to you upon hire?
- Did you receive adequate job training? If not, where was it lacking?
- Was your orientation adequate? How could it have been improved?

STAFFING AND WORKLOAD:

- Was your department adequately staffed? If not, what were the problems?
- Was your workload manageable? If not, how was it excessive?
- Were overtime assignments allocated fairly? Were they too frequent?

SUPERVISION AND TEAMWORK:

- Were co-workers generally supportive toward each other?
- Did you receive adequate support from your supervisor? Where was support lacking?
- Were there instances when your supervisor failed to treat you like a trusted, well-trained employee?
- Did your supervisor allow you to work without undue interference?
- Did you receive sufficient information and feedback during your performance reviews? How could the review process be strengthened?

HUMAN RESOURCES:

- Do you think your pay and benefits were reasonable and fair?
- Were there opportunities for promotion?
- What continuing education classes did you find most helpful? Were there classes or training programs that should have been available on a regular basis, but were not?
- Did you find written policies to be fair? If not, what policies were unfair or inconsistently enforced?

WORKING CONDITIONS AND POLICIES:

- Would you describe the overall stress level as low, medium or high?
- How could work-related stress be reduced?
- Did anyone discriminate against or harass you? Please explain.
- Was the work environment collegial and professional or hostile and intimidating?
- What suggestions do you have to improve working conditions?
- How could communication be improved between colleagues at shift change, and between facility administrators and departments?

RESIDENT SAFETY AND QUALITY OF CARE:

- Were overall staffing levels adequate to protect residents, or was there chronic understaffing?
- Have you witnessed negligence or abuse of residents while working here? If so, what occurred?
- Does any facility equipment require upgrading or repair?
- Did you consistently have the supplies and resources you needed to provide quality care? If not, what was lacking?
- How could the resident service program be enhanced?

Sample Form: Informed Choice Documentation

"Informed choice" is the counterpart of informed consent – an acknowledgment by residents or family that, before rejecting any care recommendations, they have been thoroughly advised of potential consequences. The following standard form is designed to help organizations appropriately document disclosure of these risks.

INFORMED CHOICE

1. I and/or my guardian and family members have been advised by the medical and clinical team of my proposed care/service plan.
2. I and/or my guardian and family members have been given the opportunity to participate in the care/service planning process.
3. The proposed care/service plan has been fully explained to me and/or my guardian and family members, and I/we understand the
   - *nature* of the recommended therapy and/or treatment
   - *purpose* of and need for the recommendations
   - *possible alternatives* to the recommended therapy and/or treatment
   - *potential consequences* of forgoing the recommended therapy and/or treatment
4. I/we understand that in choosing to exercise my right to refuse therapy and/or treatment, I may be endangering my health or life.
5. My/our reason for declining *[insert therapy or treatment being declined]* is as follows: _____

   _____

   _____
6. *[The following release is optional.]* I/we assume the risks and consequences attendant upon my freedom of choice, and release for myself, heirs, executors, administrators or personal representatives those healthcare professionals who have designed/consulted on my plan of care/service from any and all liability for ill effects that may result from my choice.
7. I/we acknowledge that I/we have read this document in its entirety, that I/we fully understand it, and that all blank spaces have been completed or crossed off prior to my/our signing.

Date: _____ Time: _____

Signature of resident or guardian: _____

Witnesses:

Signature of family member or other witness: _____

Signature of family member or other witness: _____

Sample Form: New Employee Orientation Checklist

Onboarding, a relatively new approach to employee orientation, emphasizes the use of active and informal teaching modes to convey practical knowledge, create workplace connections, and increase productivity and commitment. The following onboarding checklist is designed for supervisors, mentors and/or human resource representatives to help track and document a newly hired staff member's progress over the critical first three months of employment.

REQUIREMENT	CHECK WHEN COMPLETED	COMMENTS
BEFORE THE START DATE:		
1. Send an organizational welcome e-mail message or letter, and attach the first week's orientation schedule.		
2. Provide a link to the organization's website, directing the recipient to the welcome video and "fast facts" section.		
3. Call attention to the section of the website with employment information, announcements and retrievable forms.		
ON DAY 1:		
1. Greet the employee upon arrival.		
2. Introduce the immediate supervisor and peer mentor (if a human resource representative hosts first-day activities).		
3. Issue an employee identification badge and grant authorization for building access.		
4. Limit first-day paperwork to essentials only (e.g., tax forms, benefits enrollment, payroll processing information, employee behavior agreement).		
5. Provide a copy of the employee handbook or access to its online equivalent.		
6. Escort the employee around the unit, making introductions, noting key locations and describing basic operations.		
7. Debrief the new employee at the end of the day on his/her initial experiences.		
8. Provide a written recap of the day's events and a token to memorialize the first day, such as a water bottle or t-shirt emblazoned with a welcome message or logo.		
BY THE END OF DAY 7:		
1. Monitor and document the employee's attendance at mandatory orientation sessions.		
2. Review basic policy and governance issues.		
3. Introduce the employee to the organization's website and intranet platform.		
4. Give a list of the names and telephone extensions of staff members with whom the employee will interact on a regular basis.		
5. Set short-term performance goals.		
6. Communicate general job expectations and answer any questions that have arisen.		
7. Ensure that the employee is meeting with his/her mentor on a daily basis for short periods.		
8. Confirm that the employee has a basic understanding of important organizational facts and rules.		

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REQUIREMENT	CHECK WHEN COMPLETED	COMMENTS
BY THE END OF DAY 15:		
1. Assess whether initial goals have been achieved.		
2. Identify issues and concerns in need of resolution.		
3. Develop a plan to ensure acquisition of necessary skills and training within a reasonable time frame.		
4. Verify that the employee has been introduced to all co-workers and is adjusting to the new work environment.		
5. Reinforce healthy communication and problem-solving techniques.		
BY THE END OF DAY 30:		
1. Assign resident care duties commensurate with background and clinical performance to date.		
2. Monitor resident care immersion and discuss initial experiences.		
3. Review progress toward short-term performance goals.		
4. Identify and provide needed training and support.		
5. Maintain an "open-door" policy and encourage questions from the employee.		
6. Encourage the employee to continue meeting with his/her peer mentor twice a week.		
BY THE END OF DAY 45:		
1. Evaluate the employee's familiarity with the organization's mission, objectives and values.		
2. Schedule an informal coffee break or lunch get-together to discuss the employee's questions and concerns.		
3. Ask the employee for feedback regarding personal job satisfaction and any issues that have emerged.		
4. Identify at least three accomplishments for praise and three areas for improvement, and create an action plan.		
5. Begin discussing longer-term performance goals.		
BY THE END OF DAY 90:		
1. Hold a formal performance review to examine progress made toward meeting stated goals, adjusting these goals as necessary.		
2. Continue to organize lunches, discussions and other informal events that help integrate the employee into the team.		
3. Encourage the employee to maintain contact with his/her peer mentor on an ongoing basis.		
4. Request that the employee complete an onboarding experience questionnaire. (See page 5.)		

Sample Form: Planning Guide for Transition from Hospital to Aging Services Setting

Careful transitional planning is the key to maximizing the benefits of hospital treatment while significantly minimizing the risks of re-entry in aging services settings. The following checklist imparts the basic elements of an effective resident hand-off protocol.

	INDICATOR PRESENT (PROVIDE NAME, NUMBER AND DATE IF A WRITTEN POLICY OR PROCEDURE EXISTS FOR THE INDICATOR)	REVISION NEEDED? (YES/NO)	COMMENTS
INTERVENTIONS PRE-TRANSFER			
A. HOSPITAL DISCHARGE PREPARATIONS			
1. *A transition team from the hospital – including a practitioner of record, hospitalist (if applicable), case/care manager, social worker and discharge planner – is assigned* and documented in the patient's health record, along with each team member's contact information.			
2. *A transition coordinator from the aging services setting is designated,* and contact information is provided to the inpatient team.			
3. *The patient's healthcare information records are reviewed by a transition coordinator* during pre-discharge visits.			
4. *Relevant issues are discussed by the patient/family and transition coordinator,* including diagnosis, the plan for transition to the aging services setting and the importance of patient involvement in the transition process.			
5. *A meeting is scheduled to discuss the patient's pending discharge,* attended by the transition coordinator, case/care manager, social worker and hospital clinicians.			
6. *A summary of the hospital stay is written by the transition coordinator,* to be used for purposes of aging services care planning.			

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	INDICATOR PRESENT (PROVIDE NAME, NUMBER AND DATE IF A WRITTEN POLICY OR PROCEDURE EXISTS FOR THE INDICATOR)	REVISION NEEDED? (YES/NO)	COMMENTS
INTERVENTIONS PRE-TRANSFER (CONTINUED)			
B. INFORMATION EXCHANGE			
1. *A protocol is drafted regarding exchange of transitional care information between the hospital and the aging services facility,* in order to ensure shared accountability.			
2. *Patient heath information is transferred electronically whenever possible,* in order to expedite the process and enhance documentation.			
3. *A medication reconciliation process is completed,* documenting any change and/or discrepancy in medication orders from hospital admission through discharge.			
4. *Pending laboratory tests are noted,* and responsibility for follow-up is assigned to a designated staff member.			
5. *Follow-up appointments are documented using an established format,* which includes provider name, date and contact information.			
6. *A discharge planner is assigned,* who ensures that a bed is available in the receiving aging services setting.			
7. *A discharge summary is prepared by the hospital's attending practitioner,* which includes - primary diagnosis - treatments received during the hospital stay - consultations and recommendations - medications list, including last dose and stop dates for new medications - pending test results and follow-up appointments - vital signs - hospital contact name(s) and telephone numbers			
8. *Discharge orders are prepared* and transmitted to the aging services setting during the patient transfer.			

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	INDICATOR PRESENT (PROVIDE NAME, NUMBER AND DATE IF A WRITTEN POLICY OR PROCEDURE EXISTS FOR THE INDICATOR)	REVISION NEEDED? (YES/NO)	COMMENTS
INTERVENTIONS PRE-TRANSFER (CONTINUED)			
C. TRANSFER PREPARATIONS			
1. *At least 24 hours prior to the planned transfer, a verbal confirmation of the pending move is secured* from a hospital transition coordinator by a discharge planner/ social worker/case manager/care manager.			
2. *Family members/caregivers are notified of the pending transfer* by a discharge planner/social worker/case manager/care manager.			
3. *A discharge summary and relevant diagnostic reports are sent by the hospital to the patient's physician(s),* in order to ensure continuity of care.			
4. *An ambulance or other carrier is procured* by the aging services facility to transport the resident.			
5. *Transfer activities and resident status are documented* by ambulance staff/emergency medical technicians.			
INTERVENTIONS DURING AND AFTER TRANSFER			
A. INTAKE PROCESS			
1. *A practitioner and/or medical director from the aging services setting is assigned to the resident,* and is prominently identified in the resident's healthcare information record.			
2. *An admissions coordinator is identified* and alerted to the pending transfer.			
3. *The resident is received by a unit nurse,* who also accepts and reviews pertinent transfer documents.			
4. *The transfer is verbally confirmed by a transition coordinator,* who is in contact with a hospital discharge planner.			

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	INDICATOR PRESENT (PROVIDE NAME, NUMBER AND DATE IF A WRITTEN POLICY OR PROCEDURE EXISTS FOR THE INDICATOR)	REVISION NEEDED? (YES/NO)	COMMENTS
INTERVENTIONS DURING AND AFTER TRANSFER (CONTINUED)			
B. RECORDS REVIEW			
1. *The discharge summary, medication records and other transfer documents are reviewed by a registered nurse and/or transition coordinator,* who requests additional information, if necessary, from the hospital discharge contact.			
2. *The hospital's medication administration record is reviewed by a multidisciplinary team or nurse,* who completes a medication reconciliation form and documents any previously prescribed medications that are not resumed and/or other discrepancies.			
3. *The attending practitioner and/or medical director is contacted by a registered nurse,* who requests approval of the hospital practitioner orders and relays back to the hospital any previously prescribed medications that were omitted from the discharge orders or other discrepancies in prescribed orders or medications.			
4. *A registered nurse transcribes the practitioner orders* into the resident healthcare information record.			
C. TRANSITIONAL CARE PLANNING			
1. *A case/care manager and/or social worker are alerted to the resident's admission* by the admitting nurse or coordinator.			
2. *Hospital findings, resident health status, care needs and other high-priority topics are reviewed* by the admissions and transition coordinators and the resident/family.			
3. *A resident care plan is compiled by a multidisciplinary team,* which focuses on, among other issues, advance directive status, pending results of laboratory and diagnostic tests, needed follow-up appointments, medications and highlights of the hospital discharge.			

Sample Form: Resident Selection Screening

A sound resident placement process is essential to maintaining a safe and welcoming aging services environment. The following selection screening template is designed to enhance the resident intake procedure by facilitating the identification of an individual's strengths, limitations, social preferences, and physical and mental status.

RESIDENT SELECTION SCREEN

Name _____

Age _____ Sex _____ Marital status _____

Tentative move-in date _____ Completed by _____ Title _____

Date of review _____

	YES	NO	COMMENTS
I. HEALTH STATUS			
1. Has applicant experienced any of the following within the past six months? - Constipation and/or fecal impaction - Nausea and vomiting - Shortness of breath - Choking - Dizziness or fainting - Falls with or without injury - Joint aches - Hallucinations			
2. Has applicant lost five or more pounds in the last 60 days?			
3. Does applicant routinely leave a quarter or more of a meal uneaten?			
4. If applicant has dentures, does he or she frequently refuse or forget to wear them?			
5. Does applicant have broken and/or loose teeth, swollen and/or bleeding gums, or unfilled cavities?			
6. Does applicant have episodes of bladder incontinence? If so, how frequently?			
7. Does applicant have episodes of bowel incontinence? If so, how frequently?			
8. Has applicant been treated for a urinary tract infection within the past six months?			
9. Does applicant require any of the following? - Scheduled toileting plan - Incontinence pads/briefs - External catheter - Intermittent catheterization - Indwelling catheter			
10. Does applicant have a history of pressure sores and/or unhealed lesions within the last six months?			

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	YES	NO	COMMENTS
II. MEDICATION USE			
1. Does applicant take prescription medications? If so, what medications and how often?			
2. Does applicant take over-the-counter medications? If so, what medications and how often?			
3. Have prescription medications been changed in the last 30 days?			
4. If applicant self-administers any medications, have there been any lapses or problems?			
5. Does applicant take antipsychotic drugs daily?			
6. Does applicant take antipsychotic drugs on an as-needed basis for behavioral control?			
7. Does applicant take antianxiety drugs daily?			
8. Does applicant take antianxiety drugs on an as-needed basis for behavioral control?			
9. Does applicant take antidepressant drugs daily?			
III. COGNITIVE PATTERNS			
1. Does applicant frequently forget conversations after five minutes?			
2. Does applicant tend to recall events in the distant past more readily than recent occurrences?			
3. Is applicant unable to identify the current season?			
4. Does applicant have difficulty remembering his/her home address?			
5. Does applicant fail to recognize names and faces of relatives or other caregivers?			
6. Is applicant unable to make consistent, independent decisions?			
7. Does applicant display discomfort in new situations?			
8. Does applicant require frequent repetition of directions?			
9. Is applicant easily distracted?			
10. Does applicant express sadness, fears or concern of imminent death?			

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	YES	NO	COMMENTS
IV. SENSORY PATTERNS			
1. Does applicant have trouble hearing speech, television or telephone conversations?			
2. Does applicant have difficulty with noisy environments?			
3. Does applicant hear only when spoken to directly?			
4. Does applicant rely on a hearing aid and wear it when necessary?			
5. Does applicant occasionally miss part of a message?			
6. Does applicant respond inappropriately to requests?			
7. Is applicant's speech difficult for others to understand?			
8. Does applicant have difficulty completing thoughts?			
9. Is it difficult for applicant to articulate simple requests?			
10. Does applicant require large print or a magnifying glass to read?			
11. Does applicant see only light, shadows, shapes or colors?			
12. Does applicant bump into objects and people due to peripheral vision problems?			
V. BEHAVIORAL PATTERNS			
1. Does applicant express suicidal thoughts?			
2. Is applicant tearful?			
3. Is applicant lethargic?			
4. Does applicant refuse to eat, self-medicate or otherwise engage in daily activities?			
5. Does applicant wander?			
6. Is applicant restless, agitated and/or prone to pacing?			
7. Does applicant threaten others, scream or curse?			
8. Does applicant hit, shove or scratch others?			
9. Has applicant engaged in inappropriate sexual behavior, disrobed in public or smeared feces over the past 30 days?			
VI. ASSISTIVE DEVICE NEEDS			
1. Does applicant use any of the following on a daily basis? - Cane - Walker - Wheelchair - Chair alarm - Bed alarm - Bed rails			
2. Does applicant require a lap pillow or seatbelt to prevent unassisted rising from a seated position?			
3. Does applicant require special bathroom accommodations?			

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	YES	NO	COMMENTS
VII. FUNCTIONAL PERFORMANCE			
1. Does applicant require a prosthesis or brace to ambulate?			
2. Does applicant require physical support to become mobile?			
3. Does applicant require physical support and assistance when dressing?			
4. Does applicant require limited assistance with daily grooming?			
5. Does applicant require assistance transferring to and from tub?			
6. Does applicant require monitoring when bathing?			
7. Does applicant require full assistance with bathing?			
8. Does applicant require assistance transferring to and from the toilet?			
9. Does applicant require cueing to use the toilet?			
10. Does applicant require full assistance with toileting?			
11. Does applicant require encouragement or cueing to transfer from bed to chair and/or from sitting to standing position?			
VIII. CULTURAL AND INDIVIDUAL PREFERENCES			
1. Does applicant participate in ethnic rituals and celebrations?			
2. Does applicant practice his/her religious faith on a regular basis?			
3. Does applicant prefer homeopathic, holistic or other alternative care to conventional allopathic medicine?			
4. Is applicant accustomed to an openly gay, lesbian, bisexual or transgender lifestyle?			
5. Does applicant require special meals based on food preferences, allergies, ethnicity or religion?			

NEEDS ASSESSMENT SUMMARY

LEVEL OF CARE IDENTIFIED:

- ❑ Hospice
- ❑ Skilled care
- ❑ Assisted living
- ❑ Retirement community
- ❑ Home care
- ❑ Adult day care

DOCUMENTATION REQUIREMENTS:

- ❑ Completed application
- ❑ Practitioner's written order for admission
- ❑ Signed assessment by licensed healthcare professional
- ❑ Individualized care plan developed and reviewed with applicant, family and physician
- ❑ Copy of admission contract provided to applicant/family for review

TOTAL AND CONSISTENT DEPENDENCE IN THE FOLLOWING AREAS:

❑ Eating ❑ Grooming ❑ Bathing ❑ Mobility ❑ Toileting ❑ Dressing ❑ Transferring

Strategy Sheet: Building Rapport with Families and Surrogate Decision-makers

The ability to work well with family members and other substitute decision-makers is important to the risk management process in aging services settings. The following strategies can help establish effective, open relationships with surrogates and aid in minimizing potential conflicts.

- *Ensure that written directives are maintained in the resident record* and consulted by physicians, staff, family and surrogates.
- *Begin discussing care preferences with the resident from the time of admission.* Ask residents to rank their care goals and encourage them to discuss their values and priorities with physicians, staff and family members.
- *Include families in care planning.* In addition to enhancing communication and collaboration, family involvement will aid staff and providers in comprehending family dynamics.
- *Determine key treatment decisions in advance,* including cardiopulmonary resuscitation, tube feeding, hospitalization and antibiotic use. Require physicians to discuss the benefits, risks and burdens of these treatments, as well as potential alternatives.
- *Designate one person as the primary family contact/spokesperson.* By establishing a workable communication pattern at the outset, administrators and staff can avoid confusion and discord later, when critical decisions may need to be made quickly.
- *Report even minor adverse events to the family and/or decision-maker.* This strengthens trust and minimizes the likelihood of future surprises and misunderstandings. Thoroughly document all incidents and the preventive measures taken in response.
- *Cultivate an attitude of respect for family members throughout the organization.* Request staff members to ask relatives and others how they wish to be addressed, and train staff to be aware of tone, body language and conversational style. Organizational policy should mandate prompt return of telephone calls and e-mail messages.
- *Recognize relatives' need for information and support.* Encourage staff and providers to spend sufficient time to express empathy for family members, answer questions comprehensively and assess relatives' emotional state.
- *Consider the resident's and family's cultural background.* Educate staff regarding the impact of cultural diversity upon such issues as individual autonomy, family roles and grieving.
- *Train staff in techniques of defusing anger and maintaining calm.* Effective strategies include avoiding blaming and defensiveness, asking for additional information from the upset individual, and offering choices rather than making demands. Remind staff that excessive criticism, instigation of conflict, intrusiveness and similar behaviors are often reactions to anxiety or grief and should not be taken personally.
- *If necessary, incorporate family and/or surrogate dysfunction into the plan of care* and consult with legal counsel regarding utilization of behavior contracts to delineate expectations.
- *Use available resources to help resolve intrafamily disputes.* A social worker, psychologist, cleric or other trained professional may be able to aid family members in communicating with each other more effectively.
- *Establish formal mechanisms to resolve conflicts* between families or proxies and staff or physicians. This may involve introducing an ombudsman or other advocate into the process, or raising the issue with the ethics committee.
- *In extreme cases, be prepared to challenge an incompetent surrogate in court.* Legal action may be necessary if the alternative is exposing residents to harmful, substandard or risky care.

Strategy Sheet: Enhancing Family Council Functioning

Family councils serve as early warning systems for concerns that, left unaddressed, could develop into significant loss exposures. The following strategies are intended to help aging services facilities strengthen their family council and derive maximum benefit from this important sounding board.

- *Establish or re-institute a family council* if the organization currently lacks one. Arrange a discussion with interested relatives about the benefits of a functioning council and offer to help plan the first meeting.
- *Provide assistance but not leadership.* To maintain the family council's independence and openness, ensure that meetings are planned and facilitated primarily by members, without management control. Staff should never be voting members or attend meetings uninvited. However, until the council is fully operational, the staff liaison can recommend bylaws and meeting protocols, assist in drafting the meeting agenda, and suggest incremental goals and projects.
- *Educate staff and leadership about the rights, goals and benefits of the family council* in order to clarify its role and prevent misunderstandings.
- *Inform new residents and families about the council.* Dedicate a bulletin board or information table to council activities and publicize the group using flyers, newsletter articles, e-mail, facility greeters and orientation sessions. Recruitment should be ongoing, with new families introduced to family council members. Include information about the council's purpose and mission in admission packets.
- *Ensure that clear and accurate minutes of each meeting are documented,* including recording the complete names of participants and specifying measures implemented to rectify noted concerns. Minutes should be scribed by a qualified family member, reviewed for accuracy by an administrator, and circulated or posted for viewing by all residents/families.
- *Facilitate speakers and presentations.* Encourage staff members and leaders to answer questions at family council meetings and to suggest suitable outside speakers.
- *Demonstrate respect for the family council* by communicating regularly and courteously with council officers, taking council input seriously, responding within a designated timeframe to comments and questions, and treating council members as fellow stakeholders motivated by concern for loved ones.
- *Encourage follow-through and accountability* by requesting that all communication between the council and leadership be in writing.
- *Counter unnecessary negativity and conflict* by explaining to council officers that issues can be more effectively addressed when complaints are presented together with concrete suggestions for improvement and without personal blame.
- *Enhance council continuity and reduce potential burnout* by recommending that the council rotate leadership roles among active members and create committees to manage long-term projects.

Strategy Sheet: Negotiating Communication Breakdowns

Healthy relationships with residents and families begin with positive communication patterns, including a willingness to elicit questions and complaints. The following strategies can help encourage rapport with residents and their families, allowing both sides to express concerns, clarify expectations and resolve conflicts.

INITIATE THE DISCUSSION

- Encourage the resident/family to concentrate on pressing concerns: *"Take a moment or two to tell me what's bothering you right now."*
- Ask residents to describe their condition or concerns in their own words: *"Please tell me exactly what you have been worrying about."*
- Recite the facts carefully and neither embellish nor conceal the truth: *"Your admission assessment revealed _____, which supports your placement in a setting of this type."*

IDENTIFY THE PROBLEM

- Establish the primary concern: *"It seems to me that your main question is about _____."*
- Confirm one's understanding of the resident's/family's major issue: *"It sounds like you're frustrated because _____."*
- Assess the resident's external resources to manage the issue: *"Do you feel supported by family and friends?"*

ENCOURAGE FEEDBACK

- Continue the discussion until all questions have been answered: *"Do you have any other concerns you would like to talk about, or questions you would like to ask?"*
- Inquire if the resident/family has hidden doubts or fears: *"Is there any concern on your part over our commitment to service and care?"*
- Ask the resident/family member if he or she has anything to add: *"I sense there might be something else you'd like to tell me."*
- Elicit the opinions of the resident's relatives and support network: *"I'd like to know what your family and friends think about the facility and our offerings."*

ACKNOWLEDGE THE RESIDENT'S/FAMILY'S EMOTIONS AND UNSPOKEN CONCERNS

- Demonstrate that one is receptive and not preoccupied: *"I am always open to your questions and concerns, and I would be pleased to discuss them with you."*
- Assess and acknowledge nonverbal signals: *"I sense you may be disappointed in this aspect of our services."*
- Validate the resident's/family's concern: *"I fully understand why you're uneasy about _____."*

NEGOTIATE A PRACTICAL COURSE OF ACTION

- Set clear priorities: *"We should focus first on your chief concern, which is _____."*
- Use simple, direct language to describe program offerings and make service recommendations: *"Please consider participating in _____, which may help you better manage your condition."*
- Be realistic about what can and cannot be done: *"It is important to understand what services are available in this type of setting."*

HIGHLIGHT EVEN SMALL SUCCESSES AND ACCOMPLISHMENTS

- Inform the resident/family about milestones reached over the course of care: *"The first phase of therapy has succeeded in helping you _____, and we are now ready to proceed to the next phase."*
- Underscore gradual progress: *"Although you couldn't _____ when you first came to our facility, now you're able to manage this activity on your own."*

CONFRONT NONCOMPLIANCE DIRECTLY

- Assign tasks to be completed: *"For your own well-being, we expect you to perform the following activities independently: _____"*
- Be firm and clear with the resident and family about the potential consequences of noncompliance: *"Our facility has rules and regulations for the benefit of our residents and the community as a whole, and repeated noncompliance will result in _____."*

Strategy Sheet: Minimizing Window Restrictor Hazards

Windows that open are an important amenity for many residents, especially in assisted living settings. However, they also present a unique risk of injury for certain residents, prompting many organizations to consider installing restrictive devices. The following strategies are offered to help minimize the hazards associated with operable windows, without unduly limiting resident choice.

- *Underscore the organizational commitment to autonomy* by giving residents as much control of their lives, schedules and private space as their abilities allow.
- *Reserve the right to make private environments safer for some residents* – including those with cognitive impairment and clinical depression – through the use of window restrictors and the removal of potentially dangerous objects.
- *Be alert to clinical indicators in residents that warrant further window protection.* These include, but are not limited to, the following:
  - a history of elopement or attempted elopement
  - depressed mood and affect
  - clinical dementia
  - expressed suicidal ideation
  - failure to adapt easily after admission to life in the facility
  - expressed discontent over admission, especially within the first 48 hours
  - a significant degree of confusion or disorientation
- *Select window restrictor devices carefully.* All such devices should
  - include a bar or stop in the track to prevent the window from sliding open
  - unlock when fire or smoke alarms are activated
  - open in case of a power failure
  - have a remote release feature
- *Choose window restrictors that comply with all state requirements regarding residents' rights,* as well as building code and fire safety requirements.
- *Consult legal counsel regarding the negotiation of risk agreements for window restrictors,* which are generally used in borderline rather than high-risk cases. Such agreements typically
  - specify the risk posed by operable windows
  - explain how window restrictors could reduce the possibility of injury
  - require providers, residents and other relevant parties to attest that the resident has made an informed choice to accept the risk of windows that open in order to increase personal autonomy
  - indicate that the resident/family was thoroughly informed and involved in the decision-making process, especially if the resident is cognitively impaired

Strategy Sheet: Initiating a Feeding Assistants Program

Many aging services providers utilize feeding assistants (FAs) to ease staff workloads at mealtime. When implementing such a program, administrators should be cognizant of the associated risk exposures and prepared to implement appropriate preventive measures, as outlined below.

SELECTION

Residents with complex eating problems must be fed by a nurse or nurse aide. It is the responsibility of professional nursing staff to make this determination, based on the resident's comprehensive assessment and plan of care. Ensure that nursing staff utilize written selection criteria, which are in compliance with state and federal regulations, and that the selection process is documented in the resident care record. Sample guidelines for identifying residents who may benefit from dining assistance are available at **http://health.mo.gov/safety/cnaregistry/pdf/DiningAsstManual.pdf** (scroll down to page 42).

SUPERVISION

According to the Centers for Medicare and Medicaid Services (CMS), FAs who are 18 or more years old must work under the *general* supervision of an RN or LPN, while FAs who are 16 or 17 years old are to be under a nurse's direct supervision (i.e., on the same floor or unit). To protect residents, FAs must be thoroughly integrated into the organization's structure, knowing what is expected of them, who is supervising them and how they can contact a nurse swiftly in an emergency.

ASSESSMENT

The CMS ruling does not require pre-employment testing of FAs. However, from a risk management standpoint, it is advisable to have nursing staff observe and evaluate trainees' performance before they assume their regular duties. Also, FAs should be assessed at least annually by supervisory personnel, with any concerns that emerge addressed promptly and thoroughly. A sample dining assistant skills evaluation tool is available at **http://health.mo.gov/safety/cnaregistry/pdf/DiningAsstManual.pdf** (scroll down to page 40).

POLICIES AND PROCEDURES

Written protocol should reflect the input of all parties who work with FAs, including nurses and dietitians. Policies and procedures should be centrally posted, made available online, included in FA training and educational programs, and reviewed and updated regularly. Consult with legal counsel to ensure that policies comply with applicable regulations.

TRAINING

FAs should receive an annual in-service training seminar on relevant topics. General information, feeding tips and policy changes should be conveyed through staff meetings, e-mails, online postings, written bulletins and other means, as available and convenient.

CERTIFICATION

FA trainees who successfully undergo their training course should receive a state-approved certificate of completion. Maintain copies of certificates for all FAs, and verify and document that FAs trained elsewhere have been properly certified.

IDENTIFICATION

FAs are not required to wear name tags. However, since FAs are part-time and often short-term workers, they may not be recognized by residents and other staff members. Thus, ID badges are recommended from a safety and security point of view.

COMMUNICATION

Inform residents and families of the facility's FA-related policies and selection process at the time of admission, and answer any questions they may have.

DOCUMENTATION

Ensure that policies, resident assessments, certifications, performance reviews and other FA-related records are well-organized and accessible. As with any other staff member, any incidents of neglect, abuse or theft involving an FA must be carefully documented and promptly reported to the responsible state agency.

Strategy Sheet: Documenting Wounds Photographically

Photographing wounds can either enhance the defensibility of an organization or create risk in the event of a malpractice action, depending upon the consistency and thoroughness of the documentation practices. The following risk management principles are intended to guide administrators when reviewing existing policies or creating new protocols for pictorially recording wounds.

CONSULT LEGAL COUNSEL ABOUT RELEVANT LAWS AND REGULATIONS REGARDING WOUND CARE DOCUMENTATION

Wound imaging is treated in most jurisdictions as an optional supplement to the written care record. However, organizations in certain venues may be *required* to photograph wounds in order to track the condition of residents and monitor their care. Review local laws and regulations on an ongoing basis, and modify any protocols that are inconsistent with current legal standards, technology or practice.

ESTABLISH GROUND RULES GOVERNING WOUND AND SKIN DOCUMENTATION

The following strategies can help ensure that photographic records enhance rather than hinder defensibility:

- *Determine who is qualified to take digital photographs* based on specified standards of training and competence.
- *Conduct and document skin assessments upon admission and any subsequent readmission* to protect against possible allegations that a pre-existing wound developed later. (For a photographic wound documentation tool, visit the Institute for Healthcare Improvement at **http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Tools/PhotographicWoundDocumentationForm.htm**.)
- *Carefully consider the potential consequences of photographing the wounds of residents with a circulatory or renal disorder,* which may impede the healing process.
- *Thoroughly clean the wound and surrounding area before photographing it,* in order to minimize the possibility of subsequent misinterpretation.

ENSURE THAT WOUND IMAGING RULES AND PRACTICES ARE UNIFORMLY IMPLEMENTED

Employees, authorized photographers and medical staff should be conversant with protocol and policies governing wound photography and documentation. Training sessions should focus on helping staff document wounds in a thorough and consistent manner, guided by the following questions:

- Who took the photos?
- Why were the photos taken?
- When did the photo sequence begin and end?
- How did the wound stages develop?
- What national standards were used to track and monitor the wound (e.g., those promulgated by the American Professional Wound Care Association, at **www.apwca.org**, or the Wound, Ostomy and Continence Nurses Society, at **www.wocn.org**)?
- If a repeat photograph was taken, what was the reason?

INFORM RESIDENTS AND FAMILIES ABOUT IMAGING PROTOCOLS

Consider drafting a standard digital photography consent form to ensure that residents and families understand and agree to organizational policies regarding photography. (Model consent language is available from the American Health Information Management Association, at **http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_047031.hcsp?dDocName=bok1_047031**.) In addition, if clinical photography is used routinely to document care, inform incoming residents of this fact prior to admission and include it in the "Notice of Information Practices," as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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IMPLEMENT SOUND INFORMATION SECURITY POLICIES

The following measures can reduce the likelihood of loss or inappropriate disclosure of digital images:

- *Delineate and disclose the process for viewing images,* as well as protocols for evaluating and responding to external viewing requests.
- *Log photographs according to written policy,* and stipulate in detail where images will be electronically stored and how access is controlled.
- *Prohibit the use of cellular telephones for clinical photography,* because of inherent security and confidentiality risks.

MINIMIZE INFECTION RISKS

Written policy should prohibit the photographer's hands and equipment from coming into contact with the wound. If a wound must be touched for imaging purposes, a nurse or physician should assist the photographer, while wearing gloves and complying with all appropriate infection control protocols. Photographers should carry all equipment in hard cases and routinely clean cameras and appurtenances after each use to prevent cross-contamination or infection.

CREATE STANDARDS FOR IMAGE CONSISTENCY

The importance of consistent photographic technique cannot be overstated, as even slight variations in lighting, viewpoint and background may produce dramatically different impressions of wound size and condition. The following guidelines can assist authorized photographers in capturing clear and comparable images:

- *Designate a preferred type of camera,* such as a 35mm digital single-lens reflex camera with a range of available lenses.
- *Position the camera at an angle to the wound* instead of shooting from straight above.
- *Include a wide area of healthy tissue in the initial image,* in order to establish the precise location and scale of the wound.
- *Control the intensity and direction of light falling upon the subject,* using a portable electronic flash when necessary.
- *Place a calibrated color chart in the frame,* especially where color is an important factor.
- *Utilize scales when taking close-up images* in order to delineate wound size and depth.
- *Using prior wound documentation as reference, replicate the original angles, distances and lighting in subsequent photographic sessions,* with all images taken from the same anatomical side and either pre- or post-debridement.

POSITION SUBJECTS CAREFULLY TO PREVENT DISTORTION OR EXAGGERATION OF WOUNDS

If possible, residents should be photographed while lying down in order to minimize surface changes caused by muscle movement. To facilitate image comparison, utilize the same body position in sequential views and include a measuring device to indicate wound size.

EMPLOY A FLEXIBLE AND USER-FRIENDLY ARCHIVE SYSTEM

Archive software should allow application of individual audio tags, permit keyword searches to streamline image processing and management, and provide a thorough and useful record of care in the event of litigation.

FOLLOW CONSISTENT ARCHIVING PROCEDURES

Immediately after obtaining an image, download the file from the memory card to a computer for embedding of case identifiers, requisition numbers, date and time. In general, two copies of the wound image should be saved. The first copy is typically stored in its original form in a secure electronic format, such as a resident "photo album." The second copy can be uploaded to the electronic resident care record after minor processing, such as sharpening and color management. Both copies are considered admissible as evidence in a legal proceeding.

Strategy Sheet: Caring for Obese Residents

Approximately two-thirds of the adult American population is overweight to some degree, and all indicators suggest that the obesity rate among seniors will continue to increase. The following strategies represent a starting point for aging services administrators seeking to assess the organization's ability to meet the needs of obese residents.

- *Establish sound parameters and care protocols.* Routinely calculate body mass index (BMI) of residents and create written protocols for those who fall into various weight categories, such as underweight (BMI less than 18.5), overweight (BMI 25-29.9), obesity class I (BMI 30-34.9), obesity class II (35-39.9) and extreme obesity (BMI greater than 40). Care plans should encompass the full range of needs for each of these groups, including special nursing care, dietary and nutritional considerations, physical and occupational therapy, and social activities. Ensure that plans reflect the organization's current rather than aspirational capabilities.
- *Focus on diet and nutrition.* If weight reduction is indicated, this goal must be thoroughly integrated into the care plan. Attention must be paid to protein needs (including possible use of supplements), fluid intake and low-calorie snacking to assuage between-meal hunger pangs. Reasonable goals, accessible exercise programs and dietary counseling are instrumental to successful weight loss. Episodes of resident noncompliance should be documented in the resident care record and the care plan modified as necessary.
- *Consult with experts in obesity issues.* Obesity is, in many cases, a psychosocial condition. Effective treatment for binge eating and other disorders often requires the services of specialists who can address the underlying causes of these problems.
- *Encourage communication and collaboration with residents' families.* Adherence to dietary and exercise goals depends upon family understanding, cooperation and support. Physician recommendations and the potential consequences of noncompliance should be thoroughly discussed with those relatives and friends designated to receive this information.
- *Emphasize staff selection, training and education.* Employees involved in direct resident care and transport must be highly fit, knowledgeable about body mechanics, and well-trained in the use of lifts, scales, bathing systems and other assistive devices. Staff members also should receive sensitivity training designed to enhance their supportiveness and counter negative views about obesity, which can translate into discriminatory behavior, poor outcomes and potential liability.
- *Use mechanical lifts where possible.* Mechanical aids represent a constructive approach to addressing back injuries, which are among the most frequent causes of absenteeism in aging care settings. Implementing a "no-lift" policy can help reduce injuries to residents and staff, decrease turnover, protect resident dignity, bolster morale and minimize workers' compensation costs. While the initial outlay for equipment may be significant, the return on investment is generally high, in terms of reduced labor-related costs, enhanced quality of care and decreased liability.
- *Research equipment options.* Specialty furniture, equipment and supplies designed for obese individuals are now available from multiple sources. Depending upon the organization's applicant pool and long-term strategy, rental rather than purchase may be the appropriate option.
- *Recognize the social and psychological consequences of obesity.* Obese individuals often feel shame about being "fat" in a culture obsessed with thinness. Chronic isolation and a sense of stigma may lead to antisocial behavior. Staff members should be trained and encouraged to respond in an understanding, professional and compassionate manner.

Strategy Sheet: Guarding Against Bed Rail Entrapment

Entrapment occurs when a resident's head, neck or chest becomes caught between the mattress and a bedside rail, or within the rail itself. The following guidelines focus on identifying residents at greatest risk of entrapment, detecting potentially hazardous gaps in bed systems and taking action to prevent bed-related injuries.

- *Assess residents for physical or mental conditions that place them at greater risk for entrapment,* e.g., altered mental status, agitation, lack of muscle control or frequent nocturnal urination.
- *Identify other risk factors predisposing residents to entrapment,* such as
  - episodes of falling out of bed
  - a history of serious bed-related injuries
  - inability to ambulate safely to and from the toilet
  - inability to transfer safely between bed and wheelchair
  - inconsistency in notifying staff of needs
  - a previous entrapment or near-entrapment event
- *Survey the major bedside danger areas,* which are illustrated on the Food and Drug Administration website at **http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm072662.htm#8**:
  - within the bed rail
  - under the rail, either at the ends of the rail, between the rail supports or next to a single rail support
  - between the rail and the mattress
  - between split bed rails
  - between the end of the rail and the side of the footboard and headboard
  - between the footboard and headboard and the mattress end
- *Check beds whenever they show wear* and when bed accessories and components are added, changed or removed.
- *Retro-fit only with compatible pieces,* focusing on replacement mattresses and side rails. As bed components are not always interchangeable, confer with the manufacturer regarding compatibility whenever side rails and mattresses are purchased separately from the bed frame.
- *Utilize protective barriers* in compliance with regulatory standards, manufacturer recommendations and organizational policy. The following barrier devices are available:
  - *bed rail protector pads* designed to provide minimally obstructed views of the resident
  - *positioning bars* to assist the resident with turning
  - *bed rail netting* to prevent body parts from becoming wedged within the rail
  - *mattresses with raised foam edges* to prevent gaps between mattress and rail
  - *anti-skid pads* on bed frames to prevent mattress movement
  - *mattress inlays* to fill the space between rails and footboard and headboard
- *Adhere to universal bed-safety principles,* including the following:
  - *Inspect all bed frames, rails, mattresses and accessories* as part of a written maintenance program.
  - *Follow facility protocol for indications and safe use of protective restraints,* as simultaneous use of side rails and vest, waist, leg and/or arm restraints poses a significant risk to resident safety.
  - *Reassess the resident's need for bed rails immediately after an entrapment event,* as repeat events can occur within minutes, with potentially fatal results.
  - *Report entrapment events* in accordance with facility protocol and in compliance with the federal Safe Medical Devices Act of 1990 (Public Law 101-629).
  - *Securely latch bed rails* to prevent them from falling when shaken, and lower the foot rail when split rails are in use.
  - *Utilize beds that can be locked and lowered close to the floor* in lieu of side rails.

Strategy Sheet: Prescribing and Documentation Strategies to Reduce Polypharmacy

To safeguard residents and limit potential liability, care providers must commit to solid clinical and documentation practices at all stages of the medication management process. The following recommendations address critical risk issues with respect to both prescribing drugs and maintaining care records.

PRIOR TO ORDERING MEDICATION ...

- Use the active diagnoses and problem list from residents' Minimum Data Set to identify medications that are no longer warranted, and cite a clinical diagnosis as the basis for ordering any new medications.
- Assess and document any impairments that may affect drug efficacy, e.g., cognitive/visual/auditory deficits, swallowing difficulties, poor renal function or low blood pressure.
- Review known side effects, interactions and contraindications of all prescribed medications, in order to anticipate and document potential adverse reactions.
- Seek specialty input from other physicians and pharmacists, where necessary, and document any advice given.

WHEN WRITING PRESCRIPTIONS ...

- Systematically evaluate each prescribed medication, noting on record how the drug will likely benefit the resident and why this benefit outweighs associated risks.
- Start with the lowest practicable dose to achieve the desired therapeutic effect, and increase dosage slowly as necessary.
- Write a time-limited prescription whenever ordering drugs for symptomatic treatment.
- Refrain from adding medications to treat side effects of currently prescribed medications.
- Limit the number of permitted repeat prescriptions whenever possible.
- Document drug administration directions clearly – i.e., instead of using vague phrases such as "As directed" or "Give PRN," be specific, e.g., "Give two tabs when required for pain."

WHEN MONITORING DRUG EFFECTIVENESS ...

- Work as a team (including physicians, pharmacists and staff) in reviewing medication lists and eliminating drugs that are no longer necessary or are causing unwanted effects.
- Define the criteria for therapeutic monitoring, including goals of treatment, signs of progress and likely clinical indications that the drug therapy is poorly tolerated.
- Document predetermined end points of drug therapy, and review patient status frequently to determine if specific drugs are still needed.
- Investigate persistent or abrupt changes in clinical status to ascertain whether they are caused by a drug's adverse effects.

WHEN CONSIDERING WHETHER TO SIMPLIFY A DRUG REGIMEN ...

- Prioritize the review of higher-risk residents, e.g., those who take nine or more medications.
- Utilize a respected documentation tool, such as the Medication Appropriateness Index.
- Identify potential drug-drug, drug-disease and drug-food interactions, and modify the resident's medication regimen or diet accordingly.
- Reduce dosing schedules, to the extent possible.
- Cite medication safety profiles in clinical notation.
- Employ the Beers Criteria to avoid excessive doses, frequencies and durations of medications.
- Document the continued presence or absence of clinical necessity, especially regarding antipsychotics, hypnotics, laxatives and anticholinergic medications.

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WHEN DECIDING WHETHER TO CONTINUE OR STOP A MEDICATION ...

- Thoroughly assess the resident, documenting the effects of drug therapy to date and whether the condition/symptom for which the drug was ordered is resolved or under control.
- Quantify the severity of symptoms, using a 1-5 scale.
- Consider whether current drug therapy is likely to provide significant benefit in view of the resident's overall condition and life expectancy.
- Note the use and outcome of non-pharmacological treatment alternatives, such as art and music therapy, or meditation and relaxation techniques.
- Reduce or discontinue only one drug at a time, in order to ease the transition.
- Consult specialists regarding the cautious withdrawal of the following medications:
- ACE inhibitors and diuretics, when prescribed to ameliorate symptoms of heart failure
- drugs for heart rate or rhythm control, e.g., beta blockers, Digoxin, Amiodarone
- essential hormones, e.g., oral steroids, Levothyroxine
- antidepressants, antipsychotic and mood-stabilizing drugs
- anticonvulsants for epilepsy
- drugs for managing Parkinson's disease
- disease-modifying anti-rheumatic drugs
- longstanding benzodiazepines and opiates

Strategy Sheet: Evaluating and Deploying New Technology

Today, high-tech systems exist to support such essential functions as fall prevention and reporting, wander management, clinical and behavioral monitoring, sleep assessment, mobility assistance and medication compliance. The following measures can help enhance organizational procedures for evaluating and deploying new technology.

Initiate an ongoing dialogue about technological innovation and associated risks among organizational stakeholders and technology vendors. Establish a technology committee responsible for conducting research and providing answers to these critical questions, among others:

- Have the safety and effectiveness of the technology been clinically tested and quantified?
- Do the monitoring systems under consideration address patient care needs associated with significant liability exposures?
- Do existing systems and structures support the proposed new technology?
- Will the new technology help maintain the organization's status as a facility of choice, thus strengthening its competitive position and long-term viability?

Begin the acquisition process with a careful study of current processes and staff capabilities. A review of existing workflows will aid in identifying needed components and potential incompatibilities in systems under consideration, thus minimizing possible service disruption. Also, evaluate the computer skills of employees to ensure that new technology is not beyond the competence of average staff members.

Establish a formal technology assessment protocol. The assessment process should address system capabilities, vendor support and longevity, information control and other relevant factors. In addition, reviewers should ascertain how data are gathered, reported, analyzed, utilized, stored, secured and purged. Leading Age offers a variety of technology toolkits to guide the assessment and selection process at **http://www.leadingage.org/Toolkits.aspx**.

Solicit input from medical, resident care and support staff members early in the technology evaluation process. This can help minimize compatibility problems, shorten the learning curve and bolster staff acceptance of change.

Expand informed consent, documentation, cyber security and privacy policies to encompass the issues raised by monitoring technology. Wireless sensing systems entail a number of concerns – such as data ownership, vulnerability to hacking, resident privacy and informed choice – with complex legal and regulatory ramifications. Ensure that all privacy and documentation-related policies are reviewed by knowledgeable legal counsel.

Create written selection criteria for the use of remote monitoring technology. Discuss technology options thoroughly with residents and their families, and document the selection process in the resident care record. If system availability is limited, allocation decisions should be made using a case-management approach.

Provide consumers with non-threatening opportunities to engage technology. Offer educational programs to familiarize residents and families with the capabilities and safeguards incorporated into today's electronic technology. Reinforce instruction by encouraging the routine use of cellular telephones in safe zones, as well as computer games, e-mail systems, digital cameras and on-line photograph-sharing capabilities.

Institute ongoing monitoring of new technology. Both system performance and resident outcomes should be monitored on a continuous basis, with problems documented and addressed immediately, and findings analyzed and incorporated into the quality improvement process.

Emphasize the human factor. While technology is a useful tool for enhancing human abilities, it is not a substitute for a well-trained, highly motivated staff. An overemphasis on technology at the expense of adequate staffing or training can significantly increase liability exposure. New technology should be designed to support rather than supplant professional judgment.

Strategy Sheet: Use of Surveillance Cameras

Despite ongoing industry and government efforts aimed at improving the condition of residents, mistreatment remains a significant problem in aging services settings. One proposal to reduce the incidence of elder abuse involves the regulated and voluntary use of surveillance cameras. Prior to placing any surveillance equipment in a facility, leadership should implement the following measures.

- *Create guidelines for camera installation and operation,* which comply with current state laws and licensing regulations and minimize impact on resident privacy and dignity – e.g., requiring that cameras be mounted in a fixed position, in order to limit the field of vision and prevent inappropriate viewing.
- *Obtain a signed request and informed consent form from residents who wish to install a surveillance camera,* and secure written permission from roommates, staff and others who may be captured on tape. (Sample informed consent and roommate consent forms are included on pages 7-10 of the Maryland Office of Health Care Quality's "Guidelines for Electronic Monitoring," available at **http://dhmh.maryland.gov/ohcq/LTC/Docs/Reports/149report.pdf**.)
- *Post conspicuous notices throughout the building about the presence of video cameras,* and brief staff whenever a camera is installed, moved or removed.
- *Discuss surveillance policies and procedures with prospective residents and families,* and ascertain their thoughts and wishes on the subject. If differences emerge within families, mediation may be necessary.
- *Decide who will retain custody of the recordings,* how long they will be stored and under what conditions they can be viewed (e.g., on a frequent, real-time basis, or only after an incident is reported or suspected). Note that facility-owned footage is considered part of the resident's healthcare information record, subject to all applicable retention and privacy regulations at the federal and state level.
- *Agree on who will pay for camera installation,* and who is responsible for maintenance, removal and storage costs.
- *Obtain "buy-in" from staff* by explaining that the cameras are not intended to supplant personal care or intimidate employees, and reminding them that the cameras can protect them against false accusations and frivolous complaints.
- *Establish guidelines to determine whether residents are competent to request camera placement,* and obtain a signed agreement prior to installation from residents, family members and/or legal guardians, delineating the terms and conditions of the surveillance.

Motorized Scooters: Balancing Rights and Responsibilities

Motorized scooters, wheelchairs and other conveyances are increasingly common in aging care facilities. Under federal law, resident access to these assistive devices cannot be prohibited, unless a resident is found to be mentally or physically unfit to safely operate them.

However, such vehicles – if improperly utilized or maintained – may pose a threat to the drivers and to others. The following guidelines are designed to help aging services organizations implement motorized vehicle policies that respect residents' legal rights, while protecting the safety of the aging services community and minimizing potential liability.

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1. **Determine the number of motorized vehicles that can safely be accommodated within the aging care setting**, and require residents to disclose the size and type of proposed vehicles in a registration form, which is kept on file.
2. **Address the use of motorized vehicles in the admissions process**, explaining in writing that they must be operated in a safe, controlled and considerate manner that does not endanger or inconvenience other residents, staff or visitors.
3. **Request that the resident obtain documentation from a primary care physician stating the need for a motorized vehicle** and specifying the type of conveyance that will best meet the resident's needs.
4. **Consider the width of the proposed vehicle in relation to the size of facility rooms and hallways when approving use** to ensure that scooters and other vehicles do not block corridors or interfere with staff duties.
5. **Assess residents' ability to safely operate motorized vehicles**, documenting relevant physical and neurological factors – such as depth perception and reflexes – in the resident care information record.
6. **Designate authorized "lanes" and areas for operation of motorized vehicles**, and mark unobtrusive spaces for parking and charging batteries.
7. **Require the use of sensor technology on vehicles** to avoid potentially dangerous contact with persons and objects.
8. **Mount wide-angle mirrors in corridors with sharp corners or blind spots**, in order to enhance visibility and reduce collisions.
9. **Strictly prohibit driving with additional "passengers,"** as well as the towing or pushing of objects or vehicles, which may lead to toppling or other accidents.
10. **Require resident drivers to read and sign the facility's vehicle safety rules**, which should include the following, among others:
    - **All operators must drive at a safe speed** – i.e., no faster than the average walking pace of other residents.
    - **Follow basic "rules of the road,"** including riding on the right side of hallways, yielding to pedestrians, and stopping at pathways and intersections.
    - **Never operate a motorized vehicle while impaired** – e.g., when highly fatigued, under stress, or under the influence of mind-altering medications or alcohol.
    - **Exercise proper elevator etiquette**, backing vehicles out of elevators only after all other residents/staff/visitors have safely exited.
    - **Keep scooters and other conveyances in a safe and hygienic condition**, performing and documenting an annual maintenance check.
    - **Do not permit other residents to drive one's own vehicle**, and do not leave the vehicle unattended, except in designated parking areas.
11. **Clearly communicate in writing the rights, privileges and obligations pertaining to the use of motorized vehicles**, and place a signed copy in the resident care record. The following sample language may be adapted to suit facility needs:

    *[Insert name of resident] has the right and privilege to use a motorized scooter, cart, wheelchair or other means of conveyance within and around the grounds of [insert name of facility], if he/she complies with the Rules of Safe Operation and any other relevant policies and procedures regarding the use of motorized vehicles. By signing below, the resident agrees to operate the motorized vehicle in a safe manner and to show consideration for other residents, employees and visitors. The resident further agrees to assume responsibility for any damage caused by unsafe operation, neglect or failure to adhere to written policy.**
12. **Consult with legal counsel before entering into a written indemnification agreement with residents** regarding injuries to persons or damage to property resulting from unsafe use of a motorized vehicle.
13. **Appoint one staff member as "traffic judge,"** who is responsible for issuing written warnings to residents who break the rules governing use of motorized vehicles.
14. **Promptly investigate any vehicle-related complaints** and document the outcome with the organization's safety committee. If necessary, suspend resident operating privileges if violations recur.

* This sample language is for illustrative purposes only. As each organization presents unique situations and statutes may vary by state, we recommend that you consult with your attorney prior to use of this or similar sample language in your organization.

Assessment Tool: Best Practices of the Culture Change Movement

Over the past decade, advocates for the elderly have underscored the importance of a "culture change" in nursing homes, incorporating such basic concepts as greater resident choice, employee empowerment and more homelike environments. The following checklist can aid aging services organizations both in implementing culture change principles and evaluating progress toward achieving a resident-directed philosophy of care.

INITIATIVE TO BE MEASURED	YES/NO	IS THIS INITIATIVE SUPPORTED BY A WRITTEN POLICY OR DEPARTMENTAL PROCEDURE?	IF A WRITTEN POLICY EXISTS, WHEN WAS IT APPROVED AND REVIEWED?	COMMENTS
MISSION AND GOALS				
1. Has the organization articulated its culture change philosophy in a written plan that addresses these primary goals? - restore choice to residents in daily care/ services/activities - emphasize wellness, not illness - decentralize decision-making - empower staff through cross-training and permanent assignment				
2. Are both short- and long-term goals delineated in the culture change plan?				
3. Does the organization support a resident and/or family council and encourage participation?				
4. Are residents linked to the external community through voting, religious participation and other means?				
5. Are residents and family members consulted regarding social activities?				
6. Does the organization have a dining committee that gives residents and family members input into food selection and menu planning?				
7. Are intergenerational programs provided on a regular basis?				

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INITIATIVE TO BE MEASURED	YES/NO	IS THIS INITIATIVE SUPPORTED BY A WRITTEN POLICY OR DEPARTMENTAL PROCEDURE?	IF A WRITTEN POLICY EXISTS, WHEN WAS IT APPROVED AND REVIEWED?	COMMENTS
RESIDENT-DIRECTED CARE				
1. Are residents and family members consulted regarding the design of their care/service plan?				
2. Are residents allowed to determine their daily schedules?				
3. Do residents have a choice as to who performs their hands-on care/services?				
4. Are residents allowed to select the staff members who work in their area?				
5. Are residents offered choices regarding social events?				
6. Are residents allowed to decorate private and communal areas?				
7. Are dining times flexible?				
8. Are residents offered dining options beyond the daily menu?				
9. Do residents have access to a well-stocked pantry between meals and after hours?				
10. Do residents have access to a refrigerator for storage of their personal food items?				
11. Do residents have access to a kitchen with appliances for simple food preparation?				
12. Are residents allowed to bathe without interference, if capable of doing so?				
13. Do residents have choices regarding method and frequency of bathing?				
14. Can residents determine their own sleeping and waking times?				

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INITIATIVE TO BE MEASURED	YES/NO	IS THIS INITIATIVE SUPPORTED BY A WRITTEN POLICY OR DEPARTMENTAL PROCEDURE?	IF A WRITTEN POLICY EXISTS, WHEN WAS IT APPROVED AND REVIEWED?	COMMENTS
STAFF EMPOWERMENT				
1. Are direct care/service workers, residents and family members represented on the organization's senior management team?				
2. Do direct care/service workers provide input into the following types of decisions? - planning of social events - scheduling of staff shifts - hiring and assigning of staff - evaluating fellow staff members' performance - budgeting and allocating resources				
3. Does the organization utilize a self-managed team approach?				
4. Are certified nursing assistants (CNAs) included in resident care/service planning sessions?				
5. Does a staffing coordinator determine direct care/service worker schedules with employee input?				
6. Are CNAs allowed to develop their own schedules for day and evening shifts, to the extent possible?				
7. Are staff members offered leadership training opportunities?				
8. Are CNAs consistently assigned to the same group of residents each shift?				
9. Are CNAs rotated on a scheduled basis to provide care/service for different residents within a designated group?				
10. Does the organization pay for continuing educational courses for staff CNAs?				
11. Are CNAs and others given cross-training in tasks outside of their primary duties?				
12. Does the organization offer career ladders to support CNA development?				
ENVIRONMENTAL TRANSFORMATION				
1. Do residents live in compact, self-contained "neighborhoods" offering public areas and basic services, such as laundry, food preparation and dining?				
2. Have larger areas been divided into smaller, more comfortable living spaces, if possible?				
3. Have overhead public address speakers been replaced by less intrusive messaging systems?				
4. Have central nursing stations been eliminated?				
5. Are informal nursing stations, with an open and welcoming counter, integrated into the living space?				
6. Do dining rooms accommodate casual and off-hour dining?				

Assessment Tool: Effective Policies to Address Significant Liability Exposures

Written policies and procedures are the essential framework for consistent provision of care. The following tool is designed to help organizations periodically evaluate written policies in areas that are historically vulnerable to litigation, and to update provisions in light of experience and changing circumstances.

FALLS AND FALL-RELATED INJURIES

Do existing policies and procedures include provisions to

- *assess new admissions* to residential settings for fall risk?
- *create individualized care plans* for residents at high risk for falls?
- *maintain a fall-prevention program* that, among other measures, educates residents/clients, families and staff about preventive techniques?
- *promote an interdisciplinary approach* to fall assessment and prevention?
- *promptly assess injurious falls* and generate incident reports?
- *re-assess residents who fall* or experience a change in medical condition?

MEDICATION ERRORS AND POLYPHARMACY

Do existing policies and procedures include provisions to

- *adequately address medication errors* and delayed or inadequate staff response to such incidents?
- *document clinical indications* and a physician order for each drug prescribed?
- *educate staff on potential side effects of medications,* as well as common drug interactions?
- *incorporate polypharmacy and medication error management* into quality improvement and risk management processes?
- *properly dose all medications,* based on guidelines and medication history?
- *review and document all medications* when accepting new admissions to determine clinically indicated drugs?

NUTRITION AND HYDRATION

Do existing policies and procedures include provisions to

- *assess weight loss* and determine caloric intake when medically ordered?
- *identify residents with poor oral intake* by documenting daily food and fluid ingestion?
- *conduct interventions for weight loss,* with input from the dietary department and the resident's/client's family?
- *assign adequate staff* to help feed those residents who require assistance?
- *consult with speech therapy* on all residents with dysphagia or swallowing dysfunction?
- *recognize and treat pressure ulcers or infections* associated with malnutrition and dehydration?
- *record all discussions* with family regarding nutrient and hydration issues in the resident care record?
- *secure advance directives* regarding artificial nutrition and hydration?

PRESSURE ULCERS

Do existing policies and procedures include provisions to

- *assess residents for pressure ulcer development upon admission* and whenever there is a change in condition?
- *determine if the facility can adequately treat pre-existing pressure ulcers* in newly admitted residents?
- *document assessment findings on a standardized form,* e.g., the Braden or Norton assessment scale?
- *communicate with family members* regarding the presence of a pressure ulcer?
- *implement timely and adequate pressure-relief measures,* including ambulation schedules and enhanced nutrition, based upon a written care plan?
- *effectively document and illustrate pressure ulcers,* including presence and staging?
- *record physician assessment of pressure ulcers,* as well as wound care choices?

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RESTRAINT USE

Do existing policies and procedures include provisions to

- *maximize function and psychological well-being through care-planning measures,* thus obviating undue restraint use?
- *ensure compliance with federal and state regulations* governing use of restraints?
- *promote the use of the least restrictive restraint* that safety considerations permit?
- *require informed consent, a physician's order and continued reassessment* for appropriate use of physical restraints?
- *document the reason for physical restraint,* as well as release times, toileting times and ambulation frequency?
- *reduce or discontinue physical restraint* based upon ongoing assessment?
- *educate staff on types of injuries attributed to limb restraint and side-rail use,* including head and limb entrapment, strangulation and asphyxiation?
- *identify the intended uses of psychotropic medications,* in order to prohibit chemical restraint?
- *respond to family concerns* regarding excessive use of psychotropic medications?

WANDERING AND ELOPEMENT

Do existing policies and procedures include provisions to

- *identify residents for wandering or elopement risk* at the time of admission, and document assessment of this risk?
- *interview family members during the admission process* to ascertain a history of wandering or elopement?
- *design care plans that help manage behaviors associated with wandering,* such as hunger, thirst, incontinence, confusion, anxiety, restlessness and isolation?
- *carefully monitor residents for elopement behaviors* and document findings, especially during the first 72 hours of admission?
- *modify the environment* through visual markings, the use of wandering paths, calm surroundings and placement of security monitors?
- *implement a missing resident plan* and schedule regular mock elopement training exercises?

Assessment Tool: Compliance with Pain Management Guidelines

According to the American Geriatrics Society, 45 to 80 percent of nursing home residents have substantial pain, often in conjunction with cognitive deficits, resulting in assessment and treatment challenges. The following tool can help organizations audit their pain management program in relation to key clinical benchmarks.

GUIDELINE	AUDIT DATE	COMMENTS ON COMPLIANCE	ACTION TAKEN
EVALUATION OF THE RESIDENT			
A complete medical history and physical examination is conducted and documented in the resident care record, including - nature and intensity of pain - current and past treatments for pain - underlying or coexisting diseases or conditions - effect of pain on physical and mental functioning - any history of substance abuse The resident care record notes the presence of any recognized medical indications for use of a controlled substance.			
INFORMED CONSENT AND TREATMENT AGREEMENT			
The physician discusses the risks and benefits of the use of controlled substances with the resident, persons designated by the resident, or the resident's surrogate or guardian if the resident is incompetent. A signed informed consent form is obtained from the patient and placed in the medical record. If the resident is at high risk for medication abuse or has a history of substance abuse, the physician employs a written agreement with the resident, which outlines - resident responsibilities - guidelines for urine/serum medication-level screening - number and frequency of all prescription refills - reasons for discontinuing drug therapy (e.g., violation of agreement)			
PERIODIC CASE REVIEW			
At regular intervals, the physician reviews the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy is based on the physician's evaluation of progress toward stated treatment objectives, such as lessening of pain intensity and improved physical and/or psychosocial functioning. If treatment goals are not met despite medication adjustments, then the physician reevaluates the appropriateness of continued treatment. The treatment team monitors resident compliance with medication usage and related therapies.			

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GUIDELINE	AUDIT DATE	COMMENTS ON COMPLIANCE	ACTION TAKEN
CONSULTATION			
The physician refers residents for additional evaluation and treatment as necessary to achieve treatment objectives. (However, prescriptions are obtained from one physician and one pharmacy, where possible.) Special attention is given to residents in chronic pain who are deemed at risk of misusing their medications. Newly admitted residents with a history of substance abuse or with a comorbid psychiatric disorder are flagged for close assessment and/or referral to a pain management specialist.			
COMPLAINT MANAGEMENT			
Actions taken when a resident's pain cannot be adequately relieved, including notification of the attending physician, are documented in the medical record. The facility has an established response protocol for resident concerns about the effectiveness or appropriateness of pain management interventions. The resident is given a copy of the procedure outlining the options for pursuing a complaint, including the right to - speak with a designated representative - report the complaint to The Joint Commission hotline or a similar service - call the state health department			
RESIDENT CARE RECORDS			
Clinical staff maintains up-to-date, accurate, complete and accessible records, including - medical history and physical examinations - diagnostic, therapeutic and laboratory results - evaluations and consultations - treatment objectives - treatments and medications given (including date, type, dosage and quantity prescribed) - discussion of risks and benefits - instructions and agreements - periodic reviews Records are audited regularly for completeness of documentation and appropriateness of treatment plan.			

Assessment Tool: Malnutrition and Dehydration Risk Factors

Providing proper nourishment and hydration is perhaps the most critical responsibility of an aging services setting. The following tool is designed to assist organizations in identifying individual and organizational risk factors associated with malnutrition and dehydration.

INDICATOR PREDISPOSING RESIDENT TO RISK	DATE INDICATOR PRESENT	INTERVENTION(S) (INCLUDE CARE PLAN ENTRY)	FOLLOW-UP ACTION AND DATE
UNDERLYING DISEASE AND MEDICATION EFFECTS			
Does resident have an underlying disease that can impede adequate nutrition, e.g., congestive heart failure, chronic lung disease, liver impairment or kidney disease?			
Are adverse drug side effects – such as nausea, vomiting, diarrhea, cognitive disturbances or sleepiness – impeding adequate nutritional intake?			
Does resident suffer from food and drug interactions that decrease the ability of the body to absorb vitamins and minerals?			
Is resident clinically depressed?			
Has resident started taking any new medications?			
Does resident exhibit swallowing difficulties resulting from trauma to the head and neck, neuromuscular disorders, strokes, dementia and/or Parkinson's disease?			
Has resident recently lost teeth or have mouth sores, mouth pain or dentures that do not fit properly?			
Do tremors, dementia and/or agitation affect eating ability?			
PRE-EXISTING MALNOURISHMENT			
Has resident informed staff that he/she is losing weight?			
Are routine weight measurements on the decline?			
Do resident's clothes fit more loosely than usual?			
Does resident have cracked lips or a pale-looking mouth?			
Has resident complained that dentures no longer fit?			
Has hair been thinning or growing sparse?			
Do wounds seem to take longer to heal?			
Does resident appear confused (unrelated to any known underlying disease)?			
Is skin breaking down or does it seem loose?			
Does skin look or feel drier than usual?			
Do resident's eyes look sunken?			

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INDICATOR PREDISPOSING RESIDENT TO RISK	DATE INDICATOR PRESENT	INTERVENTION(S) (INCLUDE CARE PLAN ENTRY)	FOLLOW-UP ACTION AND DATE
ORAL AND DENTAL FACTORS			
Does resident fail to have dental checkups at three- to six-month intervals?			
Do arthritic hands interfere with careful cleaning of teeth?			
Does resident consume large amounts of soft, sticky or sugary foods?			
Does resident have gum recession and dentin exposure, predisposing him/her to root decay?			
Does resident grind his/her teeth?			
Are fillings, caps and dental prostheses in poor condition?			
Does resident exhibit periodontal disease, i.e., are teeth mobile and spaced, and does breath have a foul odor?			
Are dentures loose and in need of relining or remaking?			
EATING FACTORS			
Has resident's family and/or healthcare surrogate not been asked to help with eating, or otherwise remained uninvolved in the nutritional care planning and treatment process?			
Are resident's special dietary needs not being met?			
Are special diets prepared without consideration of appearance and correct serving temperature?			
Does resident's dietary plan include an over-reliance on liquid supplements?			
Does resident seem uninterested in food?			
Does resident eat only at a favored time of the day?			
Does resident take an unusually long time to eat?			
Are special eating utensils unavailable?			
Does resident express dislike for the facility's food?			
Does resident have difficulty reading the menu?			
Are alternative foods or beverages unavailable, if resident does not like what is being served?			
Does resident's dietary plan fail to account for cultural differences and personal preferences?			

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INDICATOR PREDISPOSING RESIDENT TO RISK	DATE INDICATOR PRESENT	INTERVENTION(S) (INCLUDE CARE PLAN ENTRY)	FOLLOW-UP ACTION AND DATE
FEEDING FACTORS			
Does resident have complicated feeding needs, such as difficulty swallowing, recurrent lung aspiration, or tube or parenteral/IV feedings?			
Is resident not receiving required feeding assistance at mealtime?			
Does resident require assistance (other than at mealtime) with snacks and drinks?			
Is resident unable to reach food at mealtime, due to improper positioning at the table or in bed?			
Do facility feeding assistants (FAs), if the facility employs them, lack state-approved training and certification?			
Are FAs assigned on a basis other than the charge nurse's assessment and resident's latest assessment and care plan?			
Are feeding and assistance patterns allowed to continue without regular assessment?			
Do FAs work without proper supervision by an RN or LPN?			
ENVIRONMENTAL FACTORS			
Does facility lack adequate staff to assist residents who need help eating?			
Does resident's care plan fail to include periods of exercise, exposure to fresh air, and sensory or mental stimulation?			
Has facility inadequately addressed malnutrition and feeding assistance through its staff education programs?			
Does facility's dining room provide a less than attractive and calm setting for meals?			

Assessment Tool: Fall Reduction Strategies

Approximately half of all residents of an aging services setting experience a fall during the course of a year, making falls one of the most frequent sources both of injuries and professional liability allegations. The following checklist is designed to help administrators assess living spaces and reduce environmental hazards that may contribute to resident falls.

GUIDELINE	YES OR NO	ACTION NEEDED AND DATE OF COMPLIANCE
RESIDENT PLACEMENT		
High-risk residents are assigned to rooms near nursing station.		
Residents who spend most of the day sitting are situated in areas with continuous staffing.		
RESIDENT CLOTHING		
Pant legs do not touch the floor.		
Residents do not wear slip-on tops or anything that is pulled over the head.		
Residents do not walk around in bare feet, socks or unfastened shoes.		
Shoes fit well and have thin, hard, non-slippery soles and low, unworn heels.		
FLOOR SURFACES		
Surfaces are non-skid and non-slippery.		
All spills are immediately mopped up.		
Carpets have low pile and tacked-down edges.		
If scatter rugs must be used, they are backed with non-skid material and are not placed at the top or bottom of stairs.		
Skid-proof or rubber strips are placed near sink areas.		
Elevated doorjambs are eliminated.		
Floor patterns are coordinated with changes in floor level.		
All electric cords are tacked down.		
No extension cords are used.		
Pathways and traffic areas are free of obstacles and clutter.		
Stairs		
- are free of objects and clutter		
- have no overhanging treads		
- are checked regularly for looseness or unevenness		
- have carpeting that is not torn or curled		
- have non-skid treads (for wooden stairs)		
- have well-marked and lighted edges		
- are no more than six inches high		
- have handrails on both sides		
Corridors have		
- handrails installed at proper height, where needed		
- benches placed at regular intervals		
- bright, glare-free lighting, day and night		
- non-skid, non-slip surfaces		

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GUIDELINE	YES OR NO	ACTION NEEDED AND DATE OF COMPLIANCE
FURNITURE DESIGN AND PLACEMENT		
Furniture is stable and hefty.		
Furniture is positioned in non-obstructing patterns, providing a clear traffic area.		
Shelving is within reach and sturdily affixed to wall.		
All drawers and doors open easily.		
Rooms have bedside commodes.		
Shelving and countertops have rounded edges.		
Bathrooms have		
- grab bars in baths/showers and on walls		
- hand-held showers		
- high toilet seats, so residents' legs are at a 90-degree angle		
- non-skid mats or flooring surfaces in baths/showers		
- seats in bath and shower		
- support rails on toilets		
- toilets in a color that contrasts with walls and floors		
- weight-bearing towel rods		
SEATING AND BEDS		
Chairs and couches provide good body support.		
Seating provides 90-degree angle for residents' legs.		
Chair arms are long enough to provide support when getting up.		
Wheelchair seating has appropriate cushioning.		
Wheelchair anti-rollback devices are in use.		
Wheelchairs are always locked properly.		
Bed height allows residents' feet to touch the floor with knees at a right angle.		
Beds are low to the ground.		
Residents are taught to dangle before rising from bed.		
Body-length pillows are placed on the sides of beds to create a safe barrier.		
Beds have a transition support rail.		
Bed wheels are always locked properly.		

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GUIDELINE	YES OR NO	ACTION NEEDED AND DATE OF COMPLIANCE
ALARMS AND CALL SYSTEMS		
Beds have motion alarms that sound when the occupant rises, reminding wearer to get up slowly.		
Motion alarm also alerts staff to assist the resident.		
Emergency call pendants are pinned to resident's garment to alert nurses.		
Emergency call systems can be reached from the floor.		
LIGHTING		
Lighting is glare-free and 60 to 100 watts in strength.		
Lighting source is not fluorescent.		
Windows are polarized or treated with a tinted material to reduce glare while conserving light.		
All switches are backlit.		
Light switches are easy to use and located near the door.		
Light switches – preferably motion-sensitive – are placed at the top and bottom of stairs.		
There are no abrupt changes in light level between stairs and their surroundings.		
Area under beds is lighted.		
Bedside lights are within easy reach.		
Bathrooms have an automatic nightlight.		
Walls are covered with non-glare paint.		
OUTDOORS		
Special attention is given to the following factors in external areas:		
- changes in elevation (e.g., rises, stairs and uneven terrain)		
- changes in lighting		
- seating		
- sidewalks and crosswalks		
- slippery and shifting weather conditions		
- transition areas (e.g., entrances, garages and patios)		

Assessment Tool: Effective Compliance Programming

Medicare- and Medicaid-certified aging care facilities are required to implement a compliance program in accordance with the Patient Protection and Affordable Care Act of 2010. The following tool is designed to assist compliance officers and committee members in evaluating whether existing compliance measures adequately address the seven core elements of effective compliance programs.

COMPLIANCE PROGRAM ELEMENTS	Y/N	COMMENTS
1. WRITTEN POLICIES AND PROCEDURES		
A written compliance program has been approved by the governing board, addressing specific areas of vulnerability.		
Compliance policies and procedures are contained within a centrally located manual or posted electronically on a home page.		
Compliance expectations are delineated in a written code of conduct, which is distributed to all personnel, as well as to vendors, contractors and business associates.		
Guidelines for reporting and investigating potential compliance violations are formulated and distributed to personnel, vendors and contractors.		
2. RESPONSIBILITY AND OVERSIGHT		
A chief compliance officer (CCO) or other designated individual, supported by a compliance committee, is assigned responsibility for the day-to-day operation and oversight of the compliance program.		
The CCO reports to the chief executive officer or senior management, as well as to the governing board.		
The CCO provides a comprehensive annual report of compliance activities to the governing board.		
Compliance committee members are readily accessible and meet with the CCO on at least a quarterly basis.		
The CCO and committee members are held accountable for achieving compliance-related goals.		
3. TRAINING AND EDUCATION		
Compliance training – which is provided to owners, executive leaders, board members, employees and affiliates – includes the following elements: - standards of conduct and practice - scenarios illustrating fraud, waste and abuse - job performance expectations - protocols for reporting and responding to suspected violations - disciplinary policies		
Compliance training is incorporated into orientation programs for new employees, board members and other relevant parties.		
Compliance program educators are well-trained, knowledgeable and professional in their approach.		
Compliance training sessions are carefully documented, including attendees' names and hours spent in training.		

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COMPLIANCE PROGRAM ELEMENTS	Y/N	COMMENTS
4. COMMUNICATION		
Reporting guidelines and methods – e.g., telephone hotline, written tip box, e-mail – are described in the written compliance plan.		
Reporting mechanisms allow for anonymous communication, guarantee confidentiality and eliminate the possibility of retaliation.		
Ethical standards, hypothetical violations, reporting methods and disciplinary measures are publicized through pamphlets, website postings and training sessions.		
Meetings and Q&As are held periodically to clarify compliance issues for employees, management and affiliates.		
5. MONITORING		
A system exists to identify areas and functions throughout the organization that present compliance risks.		
Areas of identified risk are subject to internal monitoring and regular external audits.		
Audit activities focus on applicable federal and state regulations, as well as private payor requirements.		
The CCO evaluates audit findings, baseline controls and survey results on an annual basis, and provides a written report of compliance program status to executive management and the governing board.		
Audits are conducted by objective, third-party professionals.		
Coding and billing safeguards ensure that claims submitted to Medicare do not violate the False Claims Act or other applicable regulations.		
Compliance standards and program functioning are regularly reviewed.		
6. INVESTIGATION		
Compliance issues uncovered during routine monitoring and audits are addressed promptly by the compliance committee.		
Possible compliance violations are investigated upon receipt of a report.		
Investigative activities are thoroughly documented, and comply with resident privacy regulations, peer review protections and risk management guidelines.		
Compliance matters are prioritized for review – e.g., a one-time overpayment is of less concern than a pattern of coding violations.		
Incidents of apparent retaliation or intimidation as a result of voluntary reporting are promptly investigated.		
7. DISCIPLINARY MEASURES		
Disciplinary policies are applied fairly and consistently to everyone within the organization (including governing board members, senior management, employees and contractors), and corrective actions follow every confirmed violation.		
Disciplinary actions are commensurate with the severity of the violation.		
The CCO and compliance committee periodically examine the number and types of disciplinary actions taken in response to reported violations.		
When required by law, disciplinary actions are reported to the appropriate external agencies, including (but not limited to) the Office of Inspector General and state medical boards.		
Self-disclosures of wrongdoing and payment refunds are thoroughly documented.		

Assessment Tool: Components of a Depression Management Program

Depression is a serious and widespread condition in aging services settings. To improve clinical outcomes and limit related financial losses, organizations should implement a comprehensive depression management program. The following series of questions is designed to aid organizations in evaluating the effectiveness of their existing depression management program or creating a new program.

REQUIREMENT	PRESENT (YES/NO)	ACTION REQUIRED	FOLLOW-UP PLAN
PROGRAM MISSION			
1. Has the organization articulated its philosophy regarding the treatment of depression in a comprehensive management plan addressing these primary goals? - prompt assessment and diagnosis of the condition - application of evidence-based clinical guidelines - optimization of the quality of life - reduction of suicide risk			
2. Does the written program include requirements for screening, assessment, reassessment and ongoing monitoring of the condition?			
3. Does the program support family participation in the treatment process, and are residents/clients and families apprised of treatment options?			
4. Is there a multidisciplinary team dedicated to the diagnosis and treatment of depression in residents/clients?			
5. Are both processes and outcomes monitored by the organization's quality improvement program?			
EDUCATION AND PREVENTION			
1. Are staff members oriented to the basic principles of depression management at time of hiring?			
2. Are ongoing education and training sessions offered to staff on screening, assessment and monitoring of depressive disorders, as well as assessment of suicide risk and suicide monitoring?			
3. Is a designated professional available to answer staff members' questions concerning the clinical management of depression?			
4. Are there community outreach activities to educate prospective residents/clients and families on depression and its management?			
5. Does the organization attempt to minimize depression by emphasizing individual choice and autonomy?			
6. Are social/recreational activities designed to be pleasurable, meaningful and creative?			
7. Are public and private spaces light, cheerful and inviting?			

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REQUIREMENT	PRESENT (YES/NO)	ACTION REQUIRED	FOLLOW-UP PLAN
SCREENING			
1. Does the referral protocol require mandatory screening of residents/clients for the presence of depressive symptoms prior to their admission?			
2. Are residents/clients screened for depression using the Geriatric Depression Scale or other scientifically tested tool?			
3. Does the screening tool address conditions that predispose the elderly to depression, including the following? - chronic illness - functional disability - longstanding pain - use of depressogenic medications - chemical imbalances due to metabolic disorders - alcoholism or other substance abuse problems - low self-sufficiency - social isolation or lack of social support - recent loss or crisis - recent change in residential setting			
4. Does the written policy specify who is responsible for performing screening activities?			
5. Are residents/clients screened at admission and readmission, upon Minimum Data Set assessment and with any change in condition?			
6. Does the written policy require a comprehensive medical examination if the following conditions (among others) are present? - weight loss or gain - appetite change - decreased interest in pleasures - irritability or anxiety - frequent crying - fatigue/loss of energy - sleep disturbance - psychomotor slowing - diminished concentration - feelings of worthlessness - suicidal thoughts			
ASSESSMENT AND TREATMENT			
1. Does written policy set forth documentation requirements for depression assessment and treatment, including the following? - primary symptoms - frequency of symptoms - behavioral disturbances - physical signs - aggravating factors - alleviating factors - cyclical features affecting appetite, emotions and physical functioning - current treatment and medications - response to treatment			
2. Is there a protocol for discussing depression evaluation results with residents/clients and family members?			
3. Does written policy stipulate when to refer residents/clients to a mental health professional?			
4. Are direct caregivers promptly informed of the need to implement suicide prevention precautions?			
5. Are agreements in place to facilitate transfer of residents/clients whose suicide risk cannot be safely managed?			

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REQUIREMENT	PRESENT (YES/NO)	ACTION REQUIRED	FOLLOW-UP PLAN
CARE PLANNING			
1. Is the depression management team responsible for communicating all assessment findings to the resident's/client's primary physician, as well as to other members of the treatment team?			
2. Are care planning goals mutually determined by the depression management team, care team, residents/clients and family members?			
3. Are residents/clients and family members apprised of therapy goals, medication adjustments and side effects, and the overall treatment plan?			
4. Do resident/client care plans include non-pharmacological approaches to depression management (i.e., psychosocial and adjunctive therapies)?			
5. Is there a multidisciplinary process to alleviate the dangers of polypharmacy when medication is used to treat depression?			
6. Are care plans updated based upon resident/client response to medications and other therapeutic interventions?			
7. Do care plans include an automatic date for medical reassessment?			
8. Is the effectiveness of pharmacological and non-pharmacological therapies regularly reassessed?			
9. Is suicide risk re-evaluated whenever the care plan is reviewed?			
MONITORING			
1. Are staff members trained to recognize both verbal and nonverbal signs of depression?			
2. Does written policy specify how frequently residents/clients should undergo comprehensive reassessment for depressive symptoms?			
3. Do all reassessments include a review of symptoms and medication effectiveness?			
4. Are all monitoring results documented in the resident's/client's healthcare record?			
5. Is there a protocol to expedite review of care in the event of worsening symptoms?			
6. Is there a procedure for measuring resident/client and family satisfaction with the depression management process?			
7. Are quality improvement findings documented and reported through established committees?			

Assessment Tool: Achieving Compliance with End-of-life Treatment Decisions

Aging care organizations are required to establish, maintain and enforce written policies and procedures regarding residents' right to formulate advance directives, including their right to accept or refuse certain life-sustaining treatments, such as artificial nutrition or cardiopulmonary resuscitation. The following questionnaire is designed to assist aging care providers in meeting compliance requirements regarding advance directives and end-of-life choices.

RISK MANAGEMENT MEASURES	YES/NO	ACTION REQUIRED
ADMISSION REQUIREMENTS		
Upon admission, are all residents provided written information concerning their right to make decisions about their care, including the right to accept or refuse medical or surgical treatment, as well as the right to formulate advance medical directives?		
Is there a procedure in place for determining whether newly admitted residents have an advance directive or other documentation relating to life-sustaining treatment?		
Are all residents who do not present with an advance directive encouraged to do so within a set time frame?		
Is there an established procedure to identify situations where a resident's advance directive cannot be followed, and to resolve the issue with the resident or a surrogate decision-maker?		
STAFF AWARENESS		
Are all staff members instructed in how to access documented advance directives from the resident care record?		
Do staff regularly reassess residents' condition and prognosis to determine whether existing advance directives remain pertinent?		
Are staff trained to identify circumstances where surrogate decision-making is required, such as a significant decline in a resident's cognitive level?		
INFORMED CHOICE		
Is the capacity to understand and make decisions about treatment issues evaluated and documented in the resident care record, along with the ability to formulate advance directives?		
Is a medical director, physician, physician assistant or nurse practitioner assigned the duty of informing the resident and/or guardian about end-of-life issues, including available treatment options and expected outcomes in light of the resident's medical condition and prognosis?		
Are residents fully informed of the risks, benefits and potential consequences of accepting or declining certain treatments, including (but not limited to) cardio-pulmonary resuscitation, artificial nutrition and hydration, mechanical ventilation, dialysis and blood transfusions?		

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RISK MANAGEMENT MEASURES	YES/NO	ACTION REQUIRED
CARE PLANNING		
Are advance directives made an integral part of the resident care planning process, and treated with the same seriousness as every other element of the plan?		
Are treatment choices and directives periodically revisited at regular intervals, as defined by written policy?		
Do geriatric nurse practitioners, if available, assist with the process of creating advance directives, and do they remain a part of the review team?		
Are advance directives evaluated at scheduled care plan sessions, along with the resident's condition, goals, progress and concerns?		
DOCUMENTATION		
Are advance directives and other treatment choices conspicuously documented in a designated area of the resident healthcare information record?		
Is the primary decision-maker identified upon admission and prominently noted in the resident healthcare information record?		
Is the initial end-of-life treatment discussion always documented, whether or not the resident chooses to execute an advance directive?		
Are documented end-of-life treatment decisions effectively communicated to the interdisciplinary care team via resident care plans, progress notes, medical orders and other methods?		
Is the rationale for end-of-life treatment decisions thoroughly documented in the resident healthcare information record?		
Are physician and/or practitioner orders checked carefully to ensure consistency with the resident's documented choices?		

Assessment Tool: Elopement Prevention and Response

Elopement can be a catastrophic occurrence for residents, families and aging services facilities alike. The first step in safeguarding residents from unnecessary harm and averting associated lawsuits and regulatory actions is to examine existing preventative and response measures. The following comprehensive self-assessment tool is designed to help organizations evaluate wandering-related practices and protocols.

RISK MANAGEMENT STRATEGIES	YES/NO	COMMENTS
RISK ASSESSMENT		
1. Are all residents assessed for risk of wandering and elopement prior to admission, in order to determine if their needs can be met by the setting?		
2. Are family members and/or caregivers asked prior to admission if the resident has a history of wandering?		
3. Are all residents assessed for risk of wandering and elopement upon admission, at least quarterly thereafter and whenever their condition changes?		
4. Is the resident's wandering behavior observed and analyzed, in order to understand the underlying causes and motivations?		
5. Are family members and caregivers included in ongoing risk assessment efforts?		
6. Do staff look for factors that may exacerbate wandering, such as changes in medication, daily routine or room/apartment location?		
7. Are all initial assessments, reassessments and observations documented in the resident's medical record and care plan?		
POLICIES AND PROCEDURES		
1. Does the organization have written policies and procedures in place regarding prevention of wandering and elopement, and are these policies and procedures consistently followed?		
2. Are written protocols in place for responding to alarms and similar situations, and are they consistently enforced?		
3. Are staff educated about response protocols, and are educational efforts documented in staff personnel files?		
4. Are elopement-related policies and procedures updated at least annually?		
5. Does the facility have written policies and procedures in place addressing missing resident situations?		
6. Are staff members trained regarding their specific role in searching for a missing resident?		
7. Are elopement drills conducted regularly, and are problems and improvement suggestions noted in the organization's safety file?		

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RISK MANAGEMENT STRATEGIES	YES/NO	COMMENTS
SAFETY PRECAUTIONS		
1. Are all doors leading to stairways equipped with alarms?		
2. Are supply closets, laundry areas, boiler rooms and other potentially unsafe places kept locked at all times?		
3. Are all bath/shower areas kept locked when not in use?		
4. Are all exit doors equipped with alarms?		
5. Are all windows equipped with opening restrictors and/or alarms or other mechanisms to alert staff of elopement attempts?		
6. Are all safety and alarm systems checked regularly to ensure they are in proper working order, and is a maintenance log kept?		
7. Do all alarm and locking systems conform to local fire and safety codes?		
8. Are all points of ingress and egress in full view of a staff member?		
9. Are all residents photographed upon admission, and are photos updated on a regular basis to reflect changes in appearance?		
10. Are photos of residents at risk for wandering maintained in a binder or other location that is accessible to caregivers, yet secured to protect residents' privacy?		
11. Are staff members informed of residents who are at elevated risk for wandering?		
12. Are staff trained in elopement prevention, and is their attendance at educational and training sessions documented in personnel files?		
13. Are efforts undertaken to ensure residents' safety documented in the resident care record?		

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RISK MANAGEMENT STRATEGIES	YES/NO	COMMENTS
BEHAVIORAL/ENVIRONMENTAL MEASURES		
1. Upon admission, are all new residents provided a tour of the building and oriented to the location of their room?		
2. Are residents who become confused reoriented regarding locations and directions?		
3. Are staff members trained to comfort anxious or agitated residents?		
4. Are staff members instructed to accompany residents who wish to spend time outdoors?		
5. Do residents take part in supervised exercise sessions?		
6. Are regular activities scheduled to provide stimulation and minimize boredom?		
7. Are food and water readily available, and are dietary considerations incorporated into the resident care plan?		
8. Are visits from family and friends encouraged?		
9. Does the facility make every effort to maximize staff continuity?		
10. Are there safe indoor and outdoor areas designated for wandering?		
11. Are electronic devices, such as ankle bracelets and laser sensors, used to alert staff that a resident is wandering?		
12. Have dead-end corridors been eliminated?		
13. Have outdoor safety hazards (such as retention ponds) been eliminated or at least enclosed by a sturdy protective fence?		
14. Are windows present throughout the facility, permitting residents to easily orient themselves as to place, season and time of day?		
15. Are residents permitted to decorate and personalize their rooms with selected items from home?		
QUALITY IMPROVEMENT PROCESS		
1. Are all elopement attempts considered an incident, and reported to the organization's risk management and quality improvement committee?		
2. Are all elopement attempts tracked for such variables as time, location and staff members on duty?		
3. Does the organization use the information gathered to detect patterns and trends in regard to elopement?		
4. If a trend is identified, are effective interventions developed and implemented to help minimize the risk?		
5. Are the results of these interventions monitored and analyzed?		

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